Child's Name:_____ **Date of Birth:**_____

Diagnosis:_____

Allergies:_____

Medications:_____

Today's Date:_____ **Form Completed By:**_____

Please answer the following questions about your child's health and development so we can help with your needs.

Staff Only ***F/U***	**Staying Healthy** **Medical Home:**_____	**YES**	**SOME-TIMES**	**NO**
	1. Do you have a medical home (family doctor or clinic) that you go to when your child is sick or needs a check-up			
	2. Does your child have regular check-ups with the medical home provider?			
	3. Are your child's immunizations up-to-date?			
	4. Are you happy with your child's weight?			
	5. Does your child brush his/her teeth at least daily?			
	6. Does your child have a check-up with a dentist every year?			
	7. Does your child have a soft formed bowel movement on a regular basis? (usually every other day)			
	8. Does your child regularly use a seat belt?			
	9. Do you understand the dangers of your child spending unsupervised time on the internet?			

Name:_____ID #:_____

Staff Only *F/U*	**Managing Your Child's Healthcare** **Drugstore:**_____	**YES**	**SOME-TIMES**	**NO**
	10. Do you understand your child's health problems?			
	11. Does your child actively participate in his/her own treatments? (medications, exercises, therapy)			
	12. Is your child learning to be responsible for some of his/her own health needs? (knowing when to take medications)			
	13. Do you feel that your child's identified needs are being met?			
	14. Do you know when, how much, and why your child gets medications? (prescription and over-the-counter, like Tylenol)			
	15. Do you know the side effects of your child's medications?			
	16. Are you able to get the medications, supplies, and/or equipment your child needs?			
	17. Are you able to pay for your child's dental care?			
	18. Do you know how to use your insurance and/or Medical Card?			
Staff Only *F/U*	**Becoming Independent**	**YES**	**SOME-TIMES**	**NO**
	19. Does your child do things alone without your help? (such as dressing, bathing, keeping room clean)			
	20. Does your child do his/her share of family chores? (pick-up toys, set table)			
	21. Is your child learning to do things around the house? (laundry, meal preparation)			

Name:_____ ID #:_____

Staff Only ***F/U***	**Emotional Health**	**YES**	**SOME-TIMES**	**NO**
	22. Do you share some special time with your child every day? (like reading together, playing games)			
	23. Does your child spend time with other children each week?			
	24. Do you know when your child is angry or upset?			
	25. Do you have time to take care of some of your own needs?			
Staff Only ***F/U***	**School & Future Planning** **School:**_____ **Grade:**_____	**YES**	**SOME-TIMES**	**NO**
	26. Do you talk with your child about what he/she would like to be when he/she grows up?			
	27. Does your child go to school regularly?			
	28. Do you think your child's schoolwork is at the right level for him/her?			
	29. Is your child doing well in school?			
	30. Does your school give your child time and space to take care of his/her health needs?			
	31. Are you and your child actively involved in your child's education? (parent/teacher conferences, school open house)			

Name:_____ ID #:_____

Staff Only ***F/U***	**Commission Satisfaction**	**YES**	**SOME-TIMES**	**NO**
	32. Are you pleased with the care you receive at the Commission?			

What would you like to see done differently:

Information You Would Like to Have:

- ❍ Growth & Development
- ❍ Health Information
- ❍ School Plans
- ❍ Medicaid
- ❍ Counseling
- ❍ Assistance Programs
- ❍ Social Security
- ❍ Transportation
- ❍ Other:_____

Your Comments:

STAFF USE ONLY: _____

Reviewed By:

Initials	Signature	Date